

PUBLIC-PRIVATE PARTNERSHIP: ITS IMPACT UPON HOSPITALS AND RELATED HEALTH-CARE INSTITUTIONS*

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As an operator, not a policy man, I have wondered what a Detroit­er can say of relevance in a state which led the union in recognizing the possibilities of Medicaid funds and scooped the rest of the country in effective utilization of the windfall of 1967. What can I add to your knowledge of the problems of institutional delivery of medical care in a place where your local problems in this field get more visible coverage even than those of the federal government?

Nonetheless I am here at the invitation of your committee, and I am going to try to tell you about a mythical institution called Midwest General Hospital. This institution is a prototype of a voluntary, general hospital, with the exceptional parts of its operation—its peaks and valleys—removed for the purpose of making it a fairly accurate replica­tion of a typical hospital in order to illustrate some of the impacts of the new partnership which is the subject for discussion on this occasion. (As in all good fiction, I make the usual disclaimer: any resemblance to a hospital or its people, living or dead, is *almost* purely coincidental.)

Come back with me to January 1966. The hospital is about four generations old. Some of its first patients were Civil War soldiers; so, in a manner of speaking, it has dealt off and on with government at the federal level during most of its existence. Nobody ever talked of a “partnership” until recently. As a matter of fact, neither the government nor Midwest would have been very much interested in a true partnership: after all, the American way is arms’-length dealings. On both sides of the fence there has always been a reluctance for one party to accept any of the responsibility for the shortcomings of the other.

Midwest General Hospital as a typical all-American voluntary, general hospital is operated by a board of trustees which is self-perpetu-

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ating. At any given time in history it has included a good cross-section of the men who make things move in the community. Founded originally to take care of the needs of the poor at a time when it was safer to stay at home when you were sick if you could afford it, it has evolved over the years into a 600-bed teaching hospital. In its part of the country it is a recognized leader in the delivery of superior hospital care through the efforts and inspiration of a first-rate medical staff. This staff has been organized according to the best traditions of the Joint Commission on Accreditation of Hospitals (although all medical attention is imparted by recognized specialists, and there is no section on general practice).

Midwest has been a teaching hospital since the days when doctors became doctors by preceptorship, and nurses became nurses by the principles of the Florence Nightingale theory of education: much work, but work supervised on an orderly basis and practiced only after basic principles were learned in a prescribed curriculum. Midwest today has a corporate commitment to internships and residencies in most of the medical specialties, a school of nursing, and preceptorship or internship programs in dietetics, laboratory technology, hospital administration, inhalation therapy, social work, and collegiate graduate and postgraduate nursing programs. About 13% of its expense budget is involved in these programs.

Midwest does not oppose the transfer of these educational responsibilities to the formal educational system whenever it appears that the job can be done better there, but at the same time it is not eager to give up programs that fill a social need.

Midwest has always considered itself as a health facility in the broad context of the word, which is defined by the National Advisory Commission on Health Facilities as "an instrumentality designed, financed, equipped, supplied, staffed, organized, and operated as an integral part of a comprehensive health-care system"—even though the hospital, in common with most of its counterparts around the country, has not accepted primary responsibility for insuring the existence of the other parts of the system.

As in most of America, aside from university-owned hospitals and a few famous group-practice clinics, the medical staff is entirely voluntary rather than employed and it is considered very much a part of the family. No major move is ever taken by the administration without

consultation with the staff through a well-organized and channeled series of advisory committees, through the executive committee, and through the joint conference committee. In common, again, with most teaching hospitals of similar origin and make-up, the board appoints the major department heads, but also makes provision for election of several "members at large" from the staff to insure that there is an element of democratic representation. The chief of staff sits with the board at all its meetings; thus communication is assured through medical channels. The so-called hospital-based specialties are handled under an arrangement called, in the vernacular, a percentage contract—a typical arrangement throughout the country west of Appalachia.

When I was in Columbia University immediately following World War II, the outpatient departments I visited usually had 200,000 to 500,000 visits a year. As a rule they were completely for indigents. One of our leaders in those days talked to us about the "honorable deficit" incurred by such a department as one measure of the way in which a hospital met its obligation to its community. Many of us were surprised to discover that elsewhere in the country this deficit was not considered honorable, and that outpatient departments very frequently were set up to offer services, at a price, to persons who could have gone to a doctor's office quite as easily as to the outpatient department.

The words private, semiprivate, and ward at Midwest refer entirely to rooms which contain one bed, two beds, or more than two beds; patients who are paying their own bills may occupy any such accommodations. Doctors on the staff may ask that their patients be hospitalized in any type of accommodation. There is no such thing as the private pavilion versus the ward.

For those people who are unable to pay their own bills, the hospital expects, by and large, to be paid by some outside agency, for in Midwest General there are no large, permanent endowments whose income is reserved for such persons. Rather, in the city where Midwest General exists there is a strong United Fund organization which analyzes the need not met from other sources and makes allocations to Midwest General and its sister institutions to help underwrite the costs of medical care for the indigent.

The doctors who take care of indigent patients do so under two circumstances: either a member of the attending staff may care for a patient and receive a comparatively small fee from some outside agency

or, more typically, the resident staff on the appropriate service takes care of the patient, and the doctor of the attending staff who is assigned to supervisory duties that particular month oversees the care for no fee. In return for this kind of supervisory service and the privilege of having primary responsibility for approximately 20% of the patient load, the resident staff gives yeoman service to the private patients of the attending staff. This ensures a good situation, sociologically as well as medically, in that one type of medical care is given to both private and staff patients, who are intermingled throughout the entire institution.

There is some research activity at Midwest General. The amount and volume of the research varies in proportion to the interests and abilities of key members of the medical staff. At times the research budget has been significant, and the hospital regularly receives grants, particularly from private sources.

Because Midwest General has a well-qualified, specialized medical staff the state university medical school has utilized the services of many of the doctors on the hospital's staff for part-time faculty duties. As a matter of fact, nearly two thirds of the entire medical staff at Midwest General serves in one capacity or another as faculty of the medical school. The considerable commitment that the hospital has in resident and intern teaching is intensified further by the presence of medical students on certain services. The medical school utilizes several of the hospitals in the city and relies heavily upon the commitment of these institutions and their medical staffs to supplement its limited budget for operating the medical school.

Midwest General is an old hospital located near the downtown area in a fairly large metropolitan area. It is therefore in a typically deteriorating neighborhood. It is an area which is under active urban renewal in a city with a heavy commitment to a Model Cities program. It is a metropolitan area whose leaders have good connections with Washington, D.C., and therefore it has the beginnings of a Council of Governments, which feels strongly that, more logically than any of the voluntary agencies, it is the proper channel for allocations of governmental monies coming into the community. "Suburban sprawl" accounts for the more than 125 people who form the body politic of the Council of Governments.

If I have been successful in painting a picture for you, it should be easily transplanted from Midwest to Southeast to Far West to North-

west to the Great Plains—in short, any place in this country, with minor variations. If it is in the Far West, the counterpart of Midwest General will be heavily in debt because of the necessity for rapid and great capital expansion following World War II. If it is in the East there will not be that kind of capital *debt*, but there will be intense capital *need* because endowments and their income have been eaten up in rapidly rising costs for welfare patients, and buildings have suffered from inadequate financing. At Midwest there are elements of both.

In January 1966 Midwest General did not have much to do with government. Midwest, of course, had its annual fight, along with the other hospitals in its area, with the county welfare department over the reimbursement rates for welfare patients (invariably the reimbursement rate comes out at less than cost).

Midwest has always taken care of a small number of wards of the federal government, but always there has been an intermediary between the hospital itself and the federal government.

Funds for crippled and afflicted children have come through a state department of welfare or public health. Care of dependents of members of the armed forces has always been reimbursed through the local Blue Cross plan. Reimbursement for research patients has been handled either through the local medical school, if applicable, or through grants administered at the hospital.

Now move up with me from January 1966 to *July* 1966, when the services at Midwest General were guaranteed to approximately 20% of its patient load by federal edict.

Immediate effects were mundane but, in the aggregate, they began to add up to a problem for Midwest. Many of these patients had been ward patients. Now they were guaranteed semiprivate rooms, and the hospital found itself with a great shortage of semiprivate rooms and an oversupply of wards. Promptly local compensation agreements between heavy industry and its union components raised ward accommodations to semiprivate; numerous local building codes had been revised so that it was no longer a simple thing to move one extra bed into what had been a private room and convert it to a semiprivate accommodation. There were specifications such as minimum cubic feet per patient, minimum numbers of baths—each a desirable standard—but they comprised a complicated problem for Midwest.

The difficulties were further complicated because the reimbursement

formula for these patients contained no element of capital cost other than traditional cost-based depreciation. The formula did contain, just prior to Medicare, a factor of 2% of line costs in recognition of certain not easily defined costs present in every enterprise. Keeping up with improvements in service and equipment, as any institution must, used all the cash available through depreciation and left nothing for major renovation. In company with all the hospitals across the country, Midwest joined the hue and cry which was made against the federal government for not realizing and doing something about this lack.

Both the Medicare and Medicaid programs promise amounts of needed *care* for their beneficiaries, but promised care can be delivered only through persons and institutions already in existence; these are not owned or controlled by the government which makes the promises. As the cost of that care rises, our great new third-party customer must take notice, and in the short three years since Medicare came on the scene, there has been a national preoccupation with the costs of the service and, from all sides, much expert advice as to how improvements in Medicare can be made. What we referred to in the early days as a *partnership* between government and Midwest General has often been a *truce*, and the relation has certainly become a major preoccupation on both sides—witness this conference.

The first and foremost effect, then, of the extension of hospital care at Midwest, with lean reimbursement, has resulted in a consequent supercaution about expenditures for new services, major renovations, and capital improvement.

Just a word about costs. Midwest General competes for employees in its metropolitan area with industry as well as with other health-care institutions. The standards for extended-care facilities have served to drain already scarce professional personnel from the general hospital to the extended-care field. Federal minimum wage standards, concurrently with the advent of Medicare, have served to force salaries up at all levels. I shall not dwell on the anomalous situation created by the Department of Health, Education, and Welfare in decrying the rapid rise in medical costs, while the Department of Labor was supporting legislation which has made the floor of the whole wage structure move upward faster than at any other time in history. Big government obviously has problems of communication just as big Midwest General has.

Somehow most of the criticism—and the efforts at correction—seem

to center around the Midwest General Hospitals. We realize that such a hospital is the most visible part of the health-care system; it is the easiest place to apply sanctions—even though the sanctions are intended to apply to the individual physician and patient. Utilization, overprescription, unnecessary in-hospital treatment, slow transfer to extended care, all functions of the attending doctor (the sacred duties of whom law is so careful to spell out)—penalties for all these sins are applied at the level of the hospital, with the result that the erstwhile relatively happy and cooperative relations at Midwest are badly strained.

So much for Medicare and Medicaid, which are programs of care for which institutions and doctors are reimbursed. If the reimbursement does not allow for the recovery of its actual financial requirements, Midwest General is doomed eventually.

The need for capital renovation and expansion is self-evident at Midwest, which has a well-maintained physical plant, but in many parts it is so out-of-date as not to meet modern requirements. Because it exists in the middle of a city Midwest has never had the benefit of Hill-Burton funds—these having been expanded to build new hospitals in outlying sections as the metropolitan area burgeoned in population or, even more commonly, for the provision of more beds in rural areas throughout the state. If the formula for reimbursement which covers all federal wards (and which will be copied, as the night follows the day, by other service-based reimbursement formulae) does not contain sufficient funds for necessary improvement, from what source shall these funds come?

Until recently I should have stopped this harangue about reimbursement at this point. Now I am compelled to record what appears to me to be a tragic end of a principle established at the beginning of the Medicare program. In a press conference within the last week, the secretary of Health, Education, and Welfare has announced that the 2% factor in the formula will be eliminated. This was done with no warning and no consultation with any representative of the voluntary hospital system of the country through which care must be given. I cannot say it better than did Edwin L. Crosby, executive vice president of the American Hospital Association, in a telegram to the secretary which said in part: “. . . it seems inconceivable to us that a step of such moment would be taken without consultation with this association which represents almost all of the participating hospitals under Title 18 and 19 of the Act . . . especially disheartening because this association and its member

hospitals worked actively to make the Medicare program work for the benefit of the elder citizens of this nation although our data indicate that the Social-Security payments to hospitals, even in their present form for the care of the elderly, do not adequately reimburse hospitals for the care rendered to these patients. . . ." Our partnership at this moment appears headed for a real test.

Now back to capital need, which does not go away, reimbursement formula or no.

Community drives for funds based on approved recommendations of the local planning council are still possible, but of late they have become less liberal; they require that their money be "matched" by some other source. Could it be that a page has been torn from the government's own book? This matching game is also a principle of government. Who is to match whom?

Community mental-health programs offer some help, but Midwest must conform to the theory of "catchment area" in order to qualify. For a central referral hospital to recast its psychiatric service into the mould of a discrete geographical boundary which has no particular relation to the location either of its psychiatric staff, or to the patterns of referring patients, is a problem that requires serious assessment.

Nursing education offers some hope, but not a very significant amount in relation to total capital need. When Midwest first investigated this possibility, it was necessary to show that there would be an increase in the number of students, and that the amount of available aid was to be in direct proportion to the amount of increase in enrollment. Fortunately, that provision has been liberalized, for Midwest had packed in as many students as it could house and educate several years before; hence, it was unable to demonstrate *any* increase in enrollment.

One of the hospital's most promising sources seems to lie in its medical-school affiliation. It is proposed that an investment of federal funds to modernize the beds at Midwest would provide an economical solution to the need for additional modern beds for an enlarged enrollment in the medical school, and the net result will be of benefit to the community and the country at large.

Educational funds for physician manpower might be available to Midwest General under conditions which would provide for effective control by teaching faculties of the teaching milieu. But this arrangement might lead to the transfer of the responsibility for the care of

patients from Midwest's board and staff to institutions and faculties whose primary aim is education and who traditionally have had less to do with the delivery of community-health care than the staff at Midwest. Thus the "gown" could conceivably begin to assume more influence than the "town" because of its financial weight rather than its primary field of interest. On the other hand, a proper coordination of these two interests should be beneficial to both—and economical for all.

Simultaneously, Midwest General is just discovering the practical problems involved in trying to modernize in its model-cities area. In spite of its early advocacy and vital participation in voluntary area-wide planning, during which it has submitted voluntarily to stringent discipline of its own aims and aspirations, it now discovers that in order to proceed at all it must have the approval of a neighborhood council which in turn reports its recommendations to a model-cities headquarters in the metropolitan area. All along this route, there are so many opportunities for ward politics as to make it virtually impossible to accomplish anything with dispatch. Where for a generation or more Midwest General has been a referral hospital for all segments of the metropolitan area it must now, according to the literal interpretation by some of these local elements, which are entirely consumer-oriented, stop and set up neighborhood health clinics, and change the makeup of its medical staff to insure that every local doctor of whatever qualification be associated in some way. The hospital must also make sure that no member of its present medical staff becomes unhappy or discontented with the restrictions placed upon him and that he continues to come down to the center of the city and teach and, as importantly at Midwest General, continue to bring his patients into the area.

To move a sewer in order to make way for construction, Midwest General must now plead its case through a bureaucracy that jeopardizes seriously its ability in view of today's rising costs to go through with the project.

I submit that what we have today is a case of altruistic aims seriously complicated by administrative patterns prescribed from long distances from the action. We are in danger of exterminating much that has been good in this country in the name of consumer representation. The question of what persons are properly representative of either consumer or professional is rapidly becoming a travesty in our metropolitan areas. It is high time that as much attention be given to proper representation by

knowledgeable purveyors and experienced organizers of health-care distribution as is given to ensuring that the inexperienced “definers of need” are included in the process. I do not defend the ultraconservative policy of not involving the consumer as practiced at times in the past. I publicly admit to the noninvolvement, but I warn now against throwing the baby out with the bathwater.

Today we have conflicts and an overlapping of jurisdiction. By the time these overlaps reach Midwest General, they permeate the organization deeply. The requirements for certification, verification, utilization review, and the like—simply because they are enforced through the payment, nonpayment, or delayed payment of the hospital bill—have caused unnecessarily strained relations among the parts of the hospital.

Remember, Midwest General is not just a building: it is an organization. From time to time parts of its organization such as its medical staff, nursing department, administration, and laboratories may become a little paranoid about their relative rank, status, and prerogatives within the institution, but traditionally there have been channels for ironing out these intrafamily problems. And these changes have included the 70,000 or more public representatives known as trustees—our vital, long-standing, and on-going links with community needs.

Today things are more difficult because regulation and custom are beginning to hit at different parts of the hospital through independent channels. Part B, for example, separated the medical staff—particularly in the hospital-based specialties—from the institution.

I fear I may leave the impression that I am preoccupied with dollars alone. We are all sophisticated enough to know the various essential components of good health service, but the impact of new developments on the operations of our facilities seem always to be in terms of dollars: a *supply* if we move in certain directions, a *dearth* if we go in others. Now an outright effect on the quality of care may occur if this ill-advised limitation on full reimbursement of cost is maintained. In other words, dollars are simply the symbols through which we communicate most plainly the impacts of which we speak.

If there lies a challenge to all of us who make up this institution I call Midwest General, it is to remember that we must rededicate ourselves to answering the criticisms of the outside world with a single voice, for it is the combined resources of the Midwest General Hospitals which provide the institutional health care for our country.